
HIPAA (Health Insurance Portability and Accountability Act) Project

# Frequently Asked Questions (and Answers) Updated

## GENERAL QUESTIONS

- What was Washington State's **implementation date for HIPAA**?
  - **October 16, 2003** -- It's the same for all providers and payers all over the nation.

- **How long will the dual support be available?**
  - This is unknown at this time. These decisions will be based on CMS and Washington Executives.

- How much notice will MAA give Providers/Submitters before **Dual Support is discontinued?**
  - This is unknown at this time. It is customary to **give at least 30 days notice.**

- **Will Washington allow parallel processing or dual support to providers?**
  - **YES –** Washington's Medicaid program will offer dual support for a limited time, meaning that providers can use their current claims-filing system as a short-term backup in case their HIPAA compliant system doesn't work or isn't ready by the 10/16 deadline.

- **I'm not** going to be **ready. Will the federal government fine me?**
  - **NOT FOR NOW** – The federal government said in September it also will use dual support during the transition period, and it encouraged all health plans to have contingency plans. This means as long as providers and payers are making good faith efforts and are close to compliance, no one should be penalized. In fact, the law was never intended to punish providers but to make life easier for them in the long run. HIPAA compliance is something that will benefit your office, so you should be working on it. However, it also is a mandate in federal law, so the grace period will not last forever.

- Can I continue to **submit paper** as I currently do now?
  - Yes.

- What if I just **revert to paper claims?** I heard you don't have to be compliant to file paper claims.
  - **DON'T DO IT!** Paper claims will dramatically slow down claims processing. It would take an enormous increase in our staffing to process any significant increase in paper claims. Our dual support will allow providers to file under their old filing systems, so there should be no need to file paper claims. But the biggest argument against it for providers is that a big increase in paper claims will simply slow everything down, including your payments.

- Are Washington providers currently **submitting through a Web site?** If so, what do they need to complete to continue that?
    - **YES** – ECS (Electronic Claims Submission) is a Web claims-filing application developed by DSHS nearly two years ago to let providers switch from paper to the Internet. Providers using ECS now can replace it with free software called WINASAP2003 that is available on our Web site. The WINASAP2003 software is HIPAA compliant. Those providers who cannot get WINASAP up and working can still use ECS during the grace period while they get their HIPAA systems ready.

- What is the process for **discontinuing service to Medicaid?**
    - Contact the Provider Enrollment line at 1-866-545-0544 Manager.

- Do Washington State providers **HAVE to bill electronically?**
    - **NOT YET –** Currently, there is no state mandate to submit electronically, but similar rules have passed in a number of other states and there is talk in the Legislature about requiring electronic billing because it would save money for both providers and the state.

- Where can I find a copy of the **companion guides?**
    - Companion guides for the different transactions are posted on the Web site of ACS, MAA's HIPAA vendor. The URL is http://www.acs-gcro.com

## BILLING INSTRUCTIONS

- Where can I find a **copy of the billing instructions?**
    - Billing instructions are posted on the MAA Web site's Provider Publications section: http://maa.dshs.wa.gov/download/billinginstructions.html

- I currently **bill Home Health claims electronically on the HCFA 1500 MACNet format.** With HIPAA, will these claim types be considered HCFA1500 or UB92 transactions?
    - These will be the same during dual support. Please check the Billing Instructions for code changes.

- **What changes do I have to make to my current electronic billing system to become HIPAA Compliant?**
    - Please refer to the implementation guides for information. You are required to have ANSI x12 HIPAA Compliant Claims.

- Who do I **call with a billing question?**
    - Call the MAA Provider Inquiry line at **1-800-562-6188.**

- Does Washington State have **Field Representatives who can visit us on site?**
    - **Yes**, although these happen infrequently because of staffing. To request a field visit, call the Field Representative Manager 360-725-1020.

- Will we continue to **get our Remittance Advice (RA) by mail?**
    - **YES – for now**. However, eventually those will go away and you will be able to receive them electronically. (MAA is working on a HIPAA compliant 835 transaction that will be available early in 2004.)

## IMPLEMENTATION GUIDE QUESTIONS

- What is the 837P **Claim Frequency Type Code**? What do I put in this field?
  - The 837 P (professional) is listed in the Implementation Guides on page 173.

- Where do I put my **Performing Provider Number**? Won't you will deny my claim if I don't have it?
  - 837P on page 297 of the Implementation Guides. Please reference – 02.

- What is my **Taxonomy Code** and where do I put it?
  - It is not a required field until the National Provider Identifier (NPI) is in place. The final NPI rule is anticipated late in December 2003. There is a 2-year implementation date after the final rule has been released.

- Will the Medicaid system begin accepting a **value of "Medicaid" in the Group Name Field** (Subscriber Information Loop 2000B:SBR4) of the 837I file?
  - It will not be necessary to populate a value of "Medicaid" in the situational SBR04 segment of the 2000B subscriber information loop of the 837I. Any information sent to report or advise of "other insurance" (any insurance in addition to Medicaid for the subscriber) will be read from the 2330B Other Payer Loop(s).

- When billing for **injectible drugs** dispensed by the provider's office, where would we report the **NDC code** corresponding to the **HCPCS or CPT code**?
  - The CPT or HCPCS would be reported in Loop 2400 Professional Service Data Segment SV101-1 and SV102-2 with the corresponding 11-digit NDC in the Drug Identification Loop 2410, LIN02 and LIN03.

- Can you tell me the **PIC (Patient Identification Code)** format for DHSH Medicaid?
  - **Loop 2010BA, Data Segment NM109 Subscriber Name.**

    For Medicaid purposes the subscriber is equal to the patient. The format for the Medicaid recipient ID is 14 characters. **First initial, Middle Initial**, *(if no middle initial use a dash)*, **birth date as MMDDYY**, **first five letters of last name** *(if last name less than five letters, space fill; if last name is a hyphenated last name the hyphen is included as one of the five characters, if last name includes an apostrophe, the apostrophe is included as one of the five characters;* **with a tiebreaker** (either alpha or numeric) as the final character. EXAMPLES:

    JD010301DOE A - Last name less than five characters

    N-020310CLINEA - No middle initial

    DL020301RUS-KA - Hyphenated last name

    NN020310O'LEA2 - Apostrophe last name

    AB010203EMANS1 - Numeric tiebreaker

    **Loop 2300 NTE - Claim Note** This field can be used at the provider's discretion. To facilitate the successful outcome of your claim, we will be reading this field for information required in various billing instructions and/or where state regulations mandate information that is not reported elsewhere within the claim data set.

    Please refer to your billing instructions and memorandums.

    An **example** would be the "I" indicator for Involuntary Treatment Act (ITA).

## PROVIDER NUMBERS

- What is the **MMIS number?**
  - The MMIS Number is the **provider's Medicaid number**. It is the way MAA identifies providers in the system.

- **How many digits are the provider numbers?**
  - The provider number is seven digits long.

- **Where do I find this number?**
  - It is on the **Remittance Advice (RA)** sheet to the right of the notation "Provider Number." Providers receive confirmation of this number when the sign up with Medicaid. If you do not have an RA, you can call the **Provider Inquiry line at 1-800-562-6188.**

- **The Submitter's packet lists three different places for numbers:**
  1. **The provider numbers** are the numbers of the individual providers in your office.
  2. **The group number** is the number that you bill under – typically, several providers in the same clinic or group use only one provider number for billing.
  3. **The submitter number** normally would be a number assigned to clearinghouses and billing agents. However, if you submit your own bills directly to Medicaid and don't use a clearinghouse, your submitter number is the number assigned to you by Medicaid when you applied for electronic claim submission.

## TESTING QUESTIONS

- **How do I create test claims?** How can I get started? How many test claims should I send?
  - The first thing you must do is get **enrolled** and **get a submitter number** for testing. Then you should call our vendor, ACS. The ACS testing call center number is: **1-850-558-1630**.

- I've downloaded **WINASAP2003. What do I do next?**
  - You should **create a test file**, just as if you were preparing a real claim, and then send it to ACS EDI. If you need assistance downloading the software, you may **call the ACS EDI Support Unit at 1-800-833-2051.**

- **What is EDIFECS?**
  - EDIFECS is a commercial software package that **tests HIPAA transactions for format and structure**. It is available to providers on the Internet. We want all Medicaid submitters use it first to make sure their claims are correctly formatted. To get set up for EDIFECS testing, call ACS at **1-850-558-1630**.

- Who do I talk to about **testing with EDIFECS?**
  - You should call the ACS testing help desk at: **1-850-558-1630.**

- How do I know that my **test claim worked in EDIFECS?**
  - The EDIFECS application provides detailed responses immediately after processing your file to explain whether the claim encountered problems or was handled correctly. (**1-850-558-1630**.)

- Can MAA provide me with a **list of Billing services, intermediaries, clearinghouses, and software** vendors that are HIPAA Compliant and MAA Approved?
  - This information is posted on the **ACS web site** at: http://www.acs-gcro.com/Medicaid_Accounts/Washington_State_Medicaid/washington_state_medicaid.htm

- How do I know whether my **clearinghouse is really testing with Medicaid?**
  - **MAA and its HIPAA vendor, ACS, will begin posting the names** of submitters that have passed the different stages of testing and the dates they passed at http://www.acs-gcro.com/Medicaid_Accounts/Washington_State_Medicaid/washington_state_medicaid.htm

- What if **my clearinghouse told me not to worry about testing,** that it would just take care of everything for me?
  - **Medicaid encourages all providers to test**. In other states, clearinghouses that failed to test their providers' live claims sometimes encountered major problems when they reached that stage. We suggest you ask your clearinghouse to send a batch of YOUR test claims to make sure they work.

- **What is the next step of testing after EDIFECS?**
  - EDIFECS checks the **format** of the claim. After EDIFECS, providers and submitters need to find out whether the **content** of the claim is correct. At the second level of testing, test claims will actually be sent into the translator, or "middleware," at the front of the MMIS system. Good claims will pass through the translator into MMIS for adjudication. Remittance advices from these test claims will be sent to you for your review of how they processed. Flawed claims will be tripped up and won't go all the way. Feedback on how your claims did is available at the ACS helpdesk. (**1-850-558-1630**.)

- How will I know whether my **test claim worked in the Middleware and was passed on to MMIS?**
  - Once the test claims are inside either the middleware or MMIS, operators of the system will be able to identify the claims and determine the problem. Feedback on how your claims did is available at the ACS helpdesk. (**1-850-558-1630**.)

- What do I do if my **claim failed? Should I resubmit it?**
  - Flawed claims should be **repaired and resubmitted** until the submitter is notified that the claim was adjudicated properly. (**1-850-558-1630**.)

- **How will I know if my claim was accepted or rejected by MMIS?**
  - Once a claim is inside MMIS, operators will be able to identify the flawed claims and determine what problems led to the stop.

- **How will I know what was wrong with my claim?**
  - A remittance advice will be sent to you that will contain the result of the claim, whether it paid or denied and the reason for denial.

- Will I receive a **copy of outcome of the adjudication so I can see whether my claim was paid?**
  - Yes, a Remittance Advice for the test claims will be sent to the provider.

## WEB PORTAL

- **What is the web portal?**
  - The **Web Portal refers to an application** that will eventually handle all the HIPAA transactions. On October 16, providers will be able to register and log on to the Web site and conduct real-time eligibility inquiries, receive real-time eligibility responses, retrieve reports such as error reports, health plan enrollment reports, etc. Eventually, providers can enter the Web portal and use it to submit claims.
- **I am having trouble logging on to the Web Portal.**
  - Call our EDI vendor, ACS, at the EDI Call Center: **1-800-833-2051**.
- **I'm able to log on but still having trouble.**
  - Call ACS: **1-800-833-2051**.

## WINASAP 2003 QUESTIONS

- I've downloaded **WINASAP2003. What do I do next?**
  - You should **create a test file**, just as if you were preparing a real claim, and then send it to ACS EDI. If you need assistance downloading the software, you may **call the ACS EDI Support Unit at 1-800-833-2051.**
- Where do I put the **EPA number**?
  - The 837D Prior Authorization/Referred number can go at the line or header. If procedure needs EPA put on line.
- What is the **Encounter Claims** box on the Claims Data Screen? Should I check it?
  - **NO**. Please **do NOT check** this box this will deny your claim for production status and you will have to re-submit your claim.